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January 19, 2016

Ms. Eileen Fleck
Chief, Acute Care Policy & Planning
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, MD 21215

Re: Draft State Health Plan for Facilities and Services: Freestanding Medical Facilities COMAR 10.24.19.

Dear Ms. Fleck:

Adventist HealthCare has reviewed the draft regulations proposed for consideration of a CON application for Freestanding Medical Facilities (FMF) in Maryland and provides these comments.

Adventist HealthCare is the non-profit, Maryland-based organization that operates Adventist HealthCare Shady Grove Medical Center; Adventist HealthCare Washington Adventist Hospital; Adventist HealthCare Behavioral Health & Wellness Services; Adventist HealthCare Physical Health and Rehabilitation; Adventist HealthCare Home Care Services, and a number of other health care programs and services.

Our other services include Adventist HealthCare Germantown Emergency Center, an FMF established as a pilot project that began serving the community in 2006. The draft chapter plan update notes on page 7 that the Germantown Emergency Center was “established to alleviate overcrowding at its parent hospital, Shady Grove Medical Center, and it appears to have significantly reduced crowding at Shady Grove Medical Center.” Indeed, we agree with this assessment. Furthermore, Adventist HealthCare appreciated the opportunity to participate in the FMF workgroup established by the Maryland Health Care Commission (Commission) that met twice in 2015.

Overview

Adventist HealthCare commends the Commission for creating an inclusive workgroup to receive input on FMF regulations, and for its work in the draft regulations that have been prepared for informal comment. In general, we believe the regulations are comprehensive and set in place an appropriate framework for making objective decisions in consideration of future FMFs in Maryland. Our specific responses to the draft regulations relate to the following sections: Issues and Policies; Rate Regulation and Financial Feasibility and Viability; Impact; Preference in Comparative Reviews; and issues related to merging the FMF and Limited Service Hospital regulations.



Issues and Policies

The draft regulations cite on page 5 that an FMF must “be an administrative part of an acute care general hospital and be physically separated from the hospital or hospital grounds.” This affirmative statement is important and we agree that consideration of future FMFs should be limited to acute care hospitals currently operating in Maryland.

On a related point, the draft regulations cite on page 7 two reasons for establishing an FMF, noting “...the establishment of an FMF may be appropriate: in response to overcrowding of the parent hospital’s ED, if the hospital or health care system has already taken steps to reduce inappropriate utilization of the parent hospital’s ED; or to improve access to emergency medical care in the service area of the parent hospital.” We believe this is an important point and agree that consideration for future FMFs should be limited to situations that address one or both of these issues.

Rate Regulation/Financial Feasibility and Viability

Pages 12 and 21 of the draft regulations address rate regulation and financial feasibility and viability noting, among other things, that the Health Services Cost Review Commission (HSCRC) “establishes budgets for each freestanding medical facility” and the HSCRC “will need to adjust the global budget of the parent hospital that is granted CON approval to establish a freestanding medical facility.” This is a critical point. The only way for needed FMFs to be viable, particularly given the EMTALA and charity care requirements, is with an appropriate reimbursement structure. We urge close collaboration between the Commission and the HSCRC in providing support for FMFs for which community need is clearly established.

Impact

One concern we have is that FMFs in the future are established to address a legitimate crowding or access need and are not used to take market share from another hospital. This is more of an issue in multi-hospital jurisdictions than rural or single hospital jurisdictions. Regarding the issue of impact, the draft regulations state that “The proposed establishment, expansion, or relocation of an FMF shall not have an undue negative effect on an existing hospital or FMF.” We note that the term “undue negative effect” is not defined and urge further clarification of this term. Similarly, the regulations state that “A project shall not have a severe adverse impact on the financial viability of any hospital or other FMF.” The term “severe adverse impact” is also not defined and can be subject to broad interpretation.

Preference in Comparative Reviews

The regulations cite criteria for choosing between competing applications in a comparative review, but do not specifically state that in cases of a comparative review the Commission has the option to choose neither application. We believe this should be clarified.

Limited Service Hospitals

During the FMF workgroup discussions Commission staff mentioned the possibility of folding Limited Service Hospital regulations into the FMF regulations, creating a two-track process of a CON for new FMFs, and a separate, non-CON process for creation of an FMF to replace a hospital that has closed. The current Limited Service Hospital regulations allow for an

emergency department to be developed within five miles of a recently closed acute care hospital. As noted during the work group discussions, five miles in an urban or multi-hospital jurisdiction is materially different than five miles in a rural area and we assert that future FMFs should be established to address a legitimate community need and not as a means to take market share from another hospital. An FMF used to replace a previous acute care hospital in a multi-hospital jurisdiction should be located on the site of the previous hospital or an immediately adjacent property, not anywhere within five miles of the previous hospital. This is especially important given that this track of the FMF regulatory process would not include the rigor of the CON process and would not allow appropriate due process for hospitals that may be impacted by an FMF located five miles from a previous hospital.

We would be happy to answer questions about these comments or provide additional information as necessary, and look forward to ongoing discussions.

Thank you for considering these comments.

Sincerely,

A handwritten signature in black ink, appearing to read "Robert E. Jepson", with a long horizontal flourish extending to the right.

Robert E. Jepson
Vice President